Investigation into the circumstances surrounding the death of a man in April 2010 at outside hospital, while in the custody of HMP Maidstone

Report by the Prisons and Probation Ombudsman for England and Wales

February 2011

This is the report of an investigation into the death of a man who died in outside hospital in April 2010. At the time of his death, the man had served 18 years of a life sentence and was a prisoner at HMP Maidstone. Just before his death, he had been diagnosed with lung cancer which had spread throughout his body. He was 56 years old.

I extend my condolences to the man's family and friends and hope this report goes some way to answering any questions they may have about his care. I am sorry that the report has been delayed and regret any additional distress this may have caused. The man was well known at Maidstone and was a well trusted and liked prisoner.

The investigation was completed by one of my colleagues. She visited Maidstone and spoke with a number of staff. One of my family liaison officers contacted the man's next of kin and invited their contribution to the investigation.

A clinical review of the treatment that the man received in custody was undertaken by a clinical reviewer who was appointed by West Kent Primary Care Trust. He assessed whether the care that the man received was of a comparable standard to that which he would have received in the community. I am grateful to the clinical reviewer for his assistance.

I would also like to thank the Governor of Maidstone and his staff for their full co-operation whilst the investigation was carried out. I would particularly like to thank the prison's family liaison officer who liaised so effectively with my investigator.

The man first reported his symptoms towards the end of 2009. Following initial treatment at the prison, he was referred to a consultant when his symptoms persisted and others appeared. A few days after his first outpatient appointment with the specialist, his condition worsened. He was admitted to hospital and subsequently died. I believe that staff made every effort to assess and treat the man's condition and made a prompt and appropriate referral to hospital. However, the failure to follow up a requested x-ray might have been a missed opportunity for an earlier diagnosis. I therefore make a recommendation in this regard and another in respect of record keeping in the healthcare department. No restraints were used during the man's stay in hospital and he was clearly treated with sensitivity in his last days. I regard this as good practice.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Jane Webb
Acting Prisons and Probation Ombudsman **February 2011**

CONTENTS

SUMMARY

The man had been a prisoner at HMP Maidstone since December 2007. He was liked by staff and prisoners and was a trusted prisoner who was allowed to paint and decorate throughout the prison.

On 26 October 2009, the man went to the prison's healthcare centre and reported chest problems and a cough. He was diagnosed with a chest infection and prescribed antibiotics. On 3 November, he told healthcare staff that he was "75 per cent better" and was given antibiotics for another five days.

His cough persisted, together with a pain in his left upper chest, between December and February 2010. One of the prison doctors requested a chest x-ray at the end of December, but there is no evidence whether it took place and it appears not to have been followed up by the healthcare staff. In the meantime, the man was treated with various antibiotics and steroid preparations. He then found a lump in his neck and was referred to the rapid access ear nose and throat clinic on 26 February.

The man had an appointment with a consultant otolaryngologist at outside hospital on 12 March. (An otolaryngologist is a specialist who diagnoses and treats illnesses of the neck and head, in particular the ear, nose and throat.) He told the man that he thought the lump was a type of tumour and arranged for further investigation. A few days later, on 16 March, the man was taken to hospital during the night, when he complained of breathing difficulties. He was later discharged and returned to the prison.

The man was admitted into outside hospital, cardiac care unit on 19 March when he had more difficulty breathing. He was subsequently moved to the High Dependency Unit of a further outside hospital on 29 March. His condition deteriorated over the next few days and he died shortly thereafter.

The prison family liaison officer had contacted a friend who the man had designated his next of kin and he visited twice before he died. The funeral costs were paid in full by the prison. The prison family liaison officer also contacted the man's wife, who was also in prison, and returned her husband's property to her, as his legal next of kin. A memorial service was held in the prison which was well attended.

I make two recommendations in regard to recording clinical matters and following up test results. I also draw attention to an example of good practice in the decision not to use restraints during the man's final days.

THE INVESTIGATION PROCESS

1. The man who is the subject of this report was 56 years old when he died at HMP Maidstone. My investigator opened the investigation on 21 April, when she visited the prison. She received copies of the man's medical and personal records and met the deputy governor. She spoke to the family liaison officer and the man's offender manager and visited the healthcare centre where the man was treated. She also talked to staff in the healthcare centre and one of the officers who was on duty escorting the man just before he died.

2. Maidstone issued notices to staff and prisoners informing them of the investigation and invited anyone who had relevant information to contact the investigator. One prisoner contacted the investigator and a colleague interviewed him on 25 June. The prisoner said that he was a very good friend of the man and thought that prison staff had treated the man with kindness and concern.

3. Kent Primary Care Trust (PCT) commissioned a clinical review of the healthcare provided to the man. The purpose of the review was to establish whether the care the man received in prison was comparable to that which he would have received in the community. I am grateful to my colleague for his review.

4. My investigator made contact with the Coroner's office to inform them of the nature and scope of the investigation. She was provided with the post mortem and toxicology findings.

5. One of my family liaison officers contacted the man's friend who was his nominated next of kin. He did not want involvement in the investigation as he was happy with the level of care his friend received. However, he will be provided with a copy of this report. My family liaison officer also made contact with the man's wife. The prison informed my investigator that the man had not had contact with his wife for some time; however his wife said that she had previously visited her husband and communicated by letters and cards up until December 2009. She added that throughout his sentence they remained friends. The FLO at Maidstone said that she went to see the man a few days before he died, as he was terminally ill and had not specified any next of kin. He told her that he wanted his friend noted as his next of kin. He did not mention that he was still married and this was only realised after he died.

6. On 22 June, my investigator and FLO visited the man's wife at HMP Send. She raised two issues. She told my investigator that she had last heard from her husband at Christmas 2009, when he wrote to her. She had found out about his illness in letters from other friends at Maidstone and was aware that he had been suffering from a chest infection and had found a lump. She was concerned that he had not been referred to hospital sooner and asked the investigator to look into this. She also asked why she had not been told that her husband was so ill in hospital and at the end of his life. My investigator explained that according to the FLO at Maidstone, her husband did not ask that she should be made aware of his condition.

HMP MAIDSTONE

7. HMP Maidstone was built in 1819 on the border of North Kent. It is a category C prison, which accommodates male prisoners and provides a therapeutic and rehabilitative programme for offenders. In May 2009, the prison held 600 prisoners, in four residential houses and a segregation unit. Around a third of the prisoners are foreign nationals.

8. The prison's healthcare unit has no inpatient facilities and does not provide 24 hour care. It is staffed from 8.00am to 5.00pm by medical staff and uses an on call locum general practitioner (GP) service.

9. An Independent Monitoring Board (IMB) is appointed to each prison by the Secretary of State for Justice. Its members are wholly independent of the Prison Service and the prison's management team. Each IMB is required to produce an annual report to the Secretary of State about the prison, highlighting good practice and any areas of concern. The most recent annual report was for the year ending February 2010. The Board said:

   "The staffing level is still below full complement and bank staff are often called upon to cover shifts. The new prisoner electronic records 'System 1' has been introduced but, regrettably, it is not interactive with the new P-Nomis system which is also in use. Clinical Governance meetings were better supported for a while by the PCT but this has since tailed off again. The Board has been advised that HMPs East Sutton Park, Blantyre House and Maidstone prisons which are clustered for Healthcare provision by the PCT is to be put out to tender during 2010. The Board receives few legitimate complaints from prisoners about healthcare provision."

10. HM Inspectorate of Prisons completed an inspection of Maidstone in 2007, which noted:

    "Staff–prisoner relationships were mixed but aspects of diversity were managed well, with particular attention paid to the needs of the large number of older and disabled prisoners. More remained to be done to address the concerns of black and minority ethnic prisoners and to support adequately the needs of foreign national prisoners. Maidstone suffered from a lack of investment in its regime … Prisoners received timed appointments to see the GP. Access to the primary care mental health service was straightforward. Several visiting health professionals held regular clinics in the prison."

KEY FINDINGS

11. The man was sentenced to life imprisonment on 19 June 1992, for serious offences. He refused to complete any offending related work throughout his sentence because he believed there had been a miscarriage of justice and he denied part of his offences. He was still actively pursuing his case when he died.

12. In 2007, the man transferred to Maidstone from HMP Elmley. There is no record of a healthscreen taking place. However, my investigator was told by the head of healthcare that the man had no health concerns. She explained that, at that time, the prison kept handwritten records. Whilst they had recently changed to a new electronic system, the previous records had not yet been inputted.

13. The head of healthcare explained that, although there was no electronic record, the man first reported chest pain and a cough on 26 October. There is a note in the man's medical record to say that his record had been merged with other patients. Therefore there are no entries between 2 January 2008 and 3 November 2009. The head of healthcare told my investigator that the man was examined in the healthcare centre (HCC) and was prescribed amoxicillin, an antibiotic. He returned to HCC on 3 November and told a member of staff that he felt 75 per cent better but wanted another seven days' amoxicillin. The notes state that his chest was clear and he was subsequently prescribed five days of amoxicillin.

14. The man went back to the HCC on 10 November, complaining of a rash. It is noted in his medical records that this was an allergic reaction to the amoxicillin and his prescription was changed to chlorophenamine 4mg. (Chlorophenamine is an antihistamine, used to prevent the symptoms of allergic reactions.) On 14 December, a doctor examined the man and noted that his chest was clear but he was still producing yellow sputum. He changed his medication to Clarithromycin, a different antibiotic often used for lung and chest infections.

15. The next entry in the medical notes was on 31 December, when the same doctor examined the man again. He complained of still having a cough, which had now continued despite antibiotics, for over two months. He also said he had a "rattly pain in his left upper chest". His appetite was good and his chest still clear. It was noted that the man was a smoker. According to the clinical review, the doctor requested blood tests and recorded that he was waiting for chest x-ray results. There is no record that a chest x-ray had either been requested or completed.

16. On 11 February, the man walked out of a GP appointment. It is not clear from the records why, or which doctor he had an appointment with at that time. However at 2.00pm on the same day, he was examined by the nurse practitioner. He complained of feeling dizzy that morning and feeling light headed at the time of his appointment. His blood pressure was normal and his pulse regular.

17. The next day, a second doctor examined the man. He noted that his chest was still problematic despite all the antibiotics he had taken. He also had swollen glands in his neck. The clinical reviewer commented that "swollen glands would

not be unexpected in someone with a chest infection". He diagnosed a chest infection and prescribed ventolin, prednisolone and salbutamol. (Ventolin is a drug used to treat wheezing. Prednisolone is a steroid that is taken to prevent asthma and shortness of breath. Salbutamol is also a drug used to treat wheezing and chest tightness.) He also arranged for the man to have blood tests, which took place on 18 February.

18. The same doctor reviewed the man a week after the previous appointment, on 19 February. He was still coughing but did not have shortness of breath. On examination of his chest, the doctor reported "left side clear but right side crackles basal" and the man was unable to "cough things up". The diagnosis remained the same but he prescribed carbocisteine capsules (to break down and thin mucous), cefalexin and clarithromycin, (both are types of antibiotics).

19. A week later, on 26 February, the same doctor examined the man again. He noted that the mass on the left side of the man's neck was no better. It was growing and had become hard. It is not entirely clear whether the doctor was referring to the swollen glands or whether the lump was a new symptom. He then referred the man to the rapid access ear nose and throat (ENT) department under the provisions for suspected cancer and took a number of blood tests.

20. On 11 March, the man went to an outpatient appointment at outside hospital in response to the rapid access referral. A consultant otolaryngologist examined him. The consultant told him that a biopsy (removal of cells for examination) was needed from the lump in his neck and it may indicate a form of tumour. The consultant arranged for a nasendoscopy (examination of the ear, nose and throat by inserting a small flexible tube to assess the lining of these areas) and an ultrasound scan with a biopsy and a computed tomography (CT) scan of his neck, chest, abdomen and pelvis. (A CT scan is a special kind of x-ray which gives a much clearer picture of the inside of the body.)

21. At midnight, the man developed difficulty in breathing. A doctor attended in response to an emergency call. He referred the man for further examination by the GP the next morning and reassured him. The next morning, the mental health nurse examined the man who seemed unclear of what he had been told by the consultant otolaryngologist and was anxious about the outcome of his tests. He also had a productive cough, which was causing him discomfort because of the lump in his neck. The nurse spent some time with him discussing the likely process of the investigations and also made a note that he had trouble sleeping over the past couple of nights. The nurse discussed the man with a further doctor, who prescribed erythromycin, an antibiotic, and zopiclone, which is a sleeping tablet, for the weekend. A review with the GP was arranged to take place on the Monday.

22. On 15 March, the GP assessed the man at the planned review. The man told him that he was finding it hard to swallow and the doctor noted a swollen lymph node in his armpit. He noted that the man was still coughing up green phlegm but was not short of breath. On examining his chest, he noted small crackles on the right side, indicating infection. In addition to the above medication, he

prescribed Fortisip. (Fortisip is a therapeutic milkshake which contains vitamins and minerals needed for a balanced diet.)

23. The clinical review established that the following day, the man was taken to the emergency care centre at outside hospital as he had difficulty breathing and chest tightness. Staff took blood tests and a chest x-ray and diagnosed a chest infection. He was reassured and discharged back to prison. No changes were made to his treatment and no follow-up appointments were arranged because the man was already being treated by the ENT consultant. The clinical reviewer was unable to find any record of this chest x-ray, or any report on the files. Neither was this attendance at outside hospital recorded in the man's prison medical notes.

24. Retrospective notes made on 12 April indicate that the man was admitted to outside hospital on 19 March after collapsing in his cell. Healthcare staff were called just after midday. He appeared short of breath and, after initial assessment and treatment, including oxygen therapy, he was taken to hospital by ambulance. As the information was not recorded at the time of his collapse, there is no detail as to whether restraints were used when he was escorted there. The man was examined and a diagnosis of cancer and pneumonia was made. He was subsequently admitted to the Medical Assessment Unit. Following further investigations, he transferred to the coronary care unit (CCU) for monitoring and treatment. He remained in the CCU until 29 March when he transferred to the high dependency unit at a further outside hospital.

25. Staff at the hospital told Maidstone prison healthcare staff that the man was suffering from renal (kidney) failure and was using a syringe driver and that his death was imminent. (A syringe driver is a small portable battery operated pump, which administers medication over a 24 hour period.) Prison staff started to arrange for the man to move to a hospice, however hospital staff advised that this was not possible because of his poor health. During the early hours of the day of his death, the man was very confused and moving in and out of consciousness. The escorting prison officer asked him how he was feeling at 6.25am and he replied, "Not too bad". At 8.50am, the man died in his sleep.

26. Throughout his time in hospital, the man was not restrained by handcuffs or any other kind of restraint and was escorted by only one officer. The prison's family liaison officer visited him a few days before his death to ask who he wanted to name as his next of kin. Although records indicate that he got married on 15 December 1994, he told her that he wanted his friend as his next of kin. His friend visited the man twice whilst he was in hospital. The man had not had contact with any family members for many years and did not give their addresses, except to say they were from Belfast. The prison's family liaison officer also contacted HMP Send and asked them to notify his estranged wife of his death. The Governor subsequently sent a condolence card to her and she was invited to his cremation. As his legal next of kin, the prison also sent official documents to her such as his death certificate. Although the prison's family liaison officer made extensive enquiries, she was unable to trace any other family members.

27. The prison paid for the man's funeral in full and held a memorial service on the wing. My investigator was told this was well attended by prisoners and the man's nominated next of kin.

Post mortem findings

28. A post mortem examination was completed on 15 April 2010. The coroner reported that in his opinion the cause of death was, "disseminated small cell carcinoma" (cancer) and thus due to natural causes.

ISSUES

Clinical care

29. A registered general nurse (RGN) conducted a review of the man's clinical care and treatment on behalf of NHS West Kent Primary Care Trust (PCT). He raised two main concerns, the follow up of a medical investigation request and the variable quality of healthcare records. He also commended good clinical practice when the man was rapidly referred to the ear, nose and throat (ENT) specialist and "exemplary emergency treatment by the prison healthcare staff, prior to him going to transfer to hospital".

30. The clinical reviewer concluded:

> "The question of whether or not the cancer should have been detected earlier is difficult to answer. A chest x-ray was planned by the GP in line with NICE guidance, a request was written on 31 December 2010, but there is no record of an x-ray report either at the prison healthcare centre or [outside hospital]."

31. The clinical reviewer also listed the following areas of concern:

- Some entries on the electronic medical record known as System One had minimal information and included abbreviations. (NMC Record Keeping Guidelines August 2009: Good practice is to avoid unnecessary use of abbreviations.)

- The GP entry in the healthcare record on 26th February was ambiguous, as it did not give clear time frame to the condition referred to. (A Clinician's Guide to Record Standards Part 1. Information Governance. Academy of Medical Royal Colleges. October 2008.)

- There is no entry recording the transfer to outside hospital Emergency Care Centre on 16 March 2010.

- A chest x-ray was requested by the GP on 31st December 2010, there is no report of it having been carried out. Enquiries at outside hospital by the reviewer did not produce any report or record of an x-ray at this time. There is no record of any attempts to follow up the x-ray request."

The reference in bullet point two above is to an entry in the medical record which states, "History; neck mass rt [right] side no better but growing and become hard, plan rapid access ENT [Ear Nose and Throat] form filled." The clinical reviewer commented that this would appear to be different from raised glands and that there is no time frame for the history. Also that the size of the lump is not mentioned and the phrase "no better" does not have a comparison.

32. In respect of the requested x-ray, I agree with the clinical reviewer's suggestion that there should be a robust system in place which includes following up any requests for investigations or tests which do not receive a timely response.

Attempts to follow up these requests should be recorded on the patient's record. He suggested:

> "This would prevent undue delay in obtaining important results and initiating further care for prisoners. By ensuring medical tests are carried out promptly, the potential health risk associated with delayed diagnosis would be reduced".

I endorse and slightly recast his recommendation:

The Head of Healthcare should ensure that there is a robust system in place to follow up any requests for diagnostic tests which do not receive a timely response and that this is fully recorded.

33. There is no record of a healthscreen taking place when the man was transferred into Maidstone. The man's clinical records had been merged with another patient and there was no recorded input between 2 January 2008 and 3 November 2009, which included his first visit to healthcare for the period of illness which precipitated his death. Furthermore, when the man attended hospital on 16 March suffering from a shortness of breath this is not recorded, nor was there an entry when he was taken to hospital on 19 March. The clinical reviewer makes three recommendations relating to record keeping which I endorse and recast in this report as a single recommendation:

The Head of Healthcare should conduct a review to improve record keeping. In particular, clinical staff should ensure that all medical notes contain information that is clear, concise and complete. They should also comply with the standards set out by the Nursing and Midwifery Council and the General Medical Council.

Good practice

34. While the man was in hospital no restraints were used and he was escorted by one officer throughout his time there. This indicates sensitivity and a sound knowledge and assessment of the man and allowed him dignity in the last few days of his life. In many reports, I have had cause to question the judgement of prison staff in applying restraints to terminally ill prisoners who are severely incapacitated, so it pleasing to note that the appropriate assessments allowed the man to die unrestrained and with dignity.

CONCLUSION

35. The man complained of chest problems in October 2009. He was treated with antibiotics and steroid preparations for a time. When he developed a lump in his neck he was referred appropriately to an ear, nose and throat specialist at a rapid access clinic. The man was admitted to hospital on 19 March 2010, and was diagnosed with cancer. Although a release to a hospice was considered, the man was not well enough to make the transition.

36. The investigation has found that the man was given appropriate care and treatment and a friend was able to visit him when he was ill. The clinical review highlights some shortcomings in following up requests for tests and record keeping at Maidstone but also commends how quickly the man was referred when he developed the lump in his neck. The clinical reviewer concluded that "generally [the man] received treatment which was appropriate and proportionate to his condition at each stage of his illness". I endorse these comments in spite of the lingering doubt as to whether the missing x-ray would have provided an earlier diagnosis.

37. I am pleased to note that on hearing that the man was coming to the end of his life, the family liaison officer visited him and ensured that his next of kin details were up to date. As well, no restraints were in place during his last days and he was only accompanied by one bedwatch officer. I believe that these arrangements were proportionate to any risk which the man might have presented, and sensitive to his dignity as his life drew to an end.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that there is a robust system in place to follow up requests for diagnostic tests which do not receive a timely response and that this is fully recorded.

   NOMS accepted the recommendation and said:

   "An individual record is now being kept in relation to requests for external diagnostic testing such as x-rays and ultrasound scans."

2. The Head of Healthcare should conduct a review to improve record keeping. In particular, clinical staff should ensure that all medical notes contain information that is clear, concise and complete. They should also comply with the standards set out by the Nursing and Midwifery Council and the General Medical Council.

   NOMS accepted the recommendation and said:

   "Staff advised with regard to this report and to be issued with NMC guidelines.

   "The Head of Healthcare will ascertain the availability of local training on record keeping for staff.

   "To be discussed at Clinical Governance meeting and with GP lead."

Good Practice

No restraints were used during the man's stay in hospital and he was escorted by one officer throughout his time there. This indicates sensitivity and a sound knowledge and assessment of the man and allowed him dignity in the last few days of his life.